

S. No. 2
DM-8-43
v. 5-17-39
1 X37823

#33928
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36821

FILED NOV 22 1944 18

Registration District No.

Primary Registration District No.

State File No.

Registrar's No.

9540

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos-25 days
(Specify whether

In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mad

(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 1510 Market St.
(If rural, give location)

(e) Citizen of foreign country? Unk. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Honora Reilly

3. (b) If veteran, name war --- 3. (c) Social Security No. ---

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased unk
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8th
year 1944 hour 9:30 minute P. M.

21. I hereby certify that I attended the deceased from 9/13/44
19 --- to Nov. 8th 19 44
that I last saw h. er alive on Nov. 8th 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized arteriosclerosis

Due to ---

Due to ---

Other conditions ---
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE: Years abt-71 Months --- Days --- If less than one day --- hr. --- min. ---

9. Birthplace unk (City, town, or county) --- (State or foreign country) A

10. Usual occupation unk

11. Industry or business ---

MOTHER FATHER { 12. Name unk

{ 13. Birthplace unk (City, town, or county) --- (State or foreign country) A

{ 14. Maiden name unk

{ 15. Birthplace unk (City, town, or county) --- (State or foreign country) A

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-11-44
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros.

(b) Address 1710 North Grand Ave.

19. (a) NOV 10 1944 (Date received local registrar) (b) J. J. Brudeck (Registrar's signature)

Major findings:
Of operations ---

Of autopsy ---

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ---

(b) Date of occurrence ---

(c) Where did injury occur? --- (City or town) --- (County) --- (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ---

While at work? --- (Specify type of place)

(c) Means of injury ---

23. Signature Herbert E. Gutz (M. D. or other) ---
Address 1515 Lafayette Date signed 11/9/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Fred Frick*

Licensed Embalmer No..... 3186

P. O. Address..... St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.